at the hospital site or within a reasonable proximity to the hospital.

Incremental Cost: the added cost incurred in alternative choices.

Independent Public Accountant: a Certified Public Accountant or Registered Public Accountant not employed by the provider.

Indirect Costs: costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

Legend Drugs: drugs for which a physician's prescription is required by state or federal law.

Look-back: a review of a facility's actual costs for a previous period prescribed by the Division.

Medicaid Resident: a nursing home resident for whom the primary payor for room and board is the Medicaid program.

New England Consumer Price Index (NECPI-U): the New England consumer price index for all urban consumers as published by DRI McGraw-Hill.

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Per Diem Cost: the cost for one day of resident care.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, HCFA-15: a manual published by the U.S. Department of Health and Human Services, Health Care Financing Administration, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Related organization or related party: an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

Resident Assessment Form: Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

Resident Day: the care of one resident for one day of services. The day of admission is counted as one day of care, but the day of discharge or death is not. A paid hold day is counted as a resident day.

Restricted Funds and Revenue: funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

RUGS-III: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Secretary: the Secretary of the Agency of Human Services.

Specialty nursing facilities: those facilities serving populations with distinct characteristics not generally applicable to nursing facilities.

Standardized Resident Days: Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-Bed: a hospital bed used to provide nursing facility services.

17 TRANSITIONAL PROVISIONS

17.1 Special Transitional Rates for Residents of the Vermont State Hospital Nursing Facilities

(a) For residents of Vermont State Hospital Nursing Facilities transferred into another Vermont licensed nursing facility (receiving facility) a special transitional per diem rate is available.

(b) The special transitional rate payable for each transferred resident shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a supplemental incentive payment, to help defray the anticipated transitional expense of accommodating the needs of the transferred residents.

(1) Transferred residents shall be grouped into classes by the Department of Developmental and Mental Health Services in consultation with the Division of Licensing and Protection, based on the anticipated difficulty of and resources needed for the transition. The amount of the supplemental payment shall be based on the classification of the resident.

(2) The per diem supplemental payment shall be payable as a lump sum for up to one year from the date of the transfer or to June 30, 1994, whichever period is the shorter, as long as the transferred person remains resident in the facility. Any advance payments for days during which the transferred person is not resident will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

(3) For transferred persons still resident in the receiving facility after June 30, 1994, the per diem supplemental payment will continue to be paid as long as the following criteria are satisfied:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred resident continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(c) The transferred resident's current case-mix score in the Vermont State Hospital Nursing Facilities (as determined by the Division of Licensing and Protection before transfer) shall be assigned to the transferred resident for two quarters after the transfer and shall be used as the minimum score for that resident in the calculation of the facility's aggregate case-mix score. For subsequent quarters, the score shall be based on normal resident assessment procedures.

(d) To be eligible for a special transitional rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Department of Developmental and Mental Health Services and the Division of Licensing and Protection.

17.2 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 110 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

17.3 **Quality Incentives**

Certain supplemental payments may be made to nursing facilities providing a superior quality of care in an efficient and effective manner, to be used for facility quality enhancements.

(a) Objective Standards. Supplemental payments will be based on:

(1) objective standards of quality to be determined for the Department of Aging and Disabilities, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental Payments.

(1) The supplemental payments may be made periodically from a quality incentive pool to certain nursing facilities whose operations meet the standards established pursuant to this subsection.

(2) Supplemental payments shall be expended by the provider to enhance the quality of care provided in the facility. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(c) The quality and efficiency standards established under this subsection, and the method of distribution of the quality incentive pool shall be subject of a notice of practices and procedures issued pursuant to Subsection 1.8(d) of these rules.

17.4 **Wage Supplement**

(a) Beginning with the state fiscal year 2000 until such time as all cost categories have been rebased on a base year no earlier than calendar year 2000, each facility shall receive a wage supplement paid from the net revenues appointed for the purpose by 33 V.S.A. §1956(b). The supplement shall be in addition to the total per diem rate as calculated pursuant to sections §§5-9, including the inflation factors in subsection §5.8. The wage supplement shall not be subject to the payment limits in subsections §§7.2(d), 7.3(d) and 7.4(d), but shall be subject to the aggregate upper payment limits in subsection §5.5(a).

(1) Each facility's annual wage supplement payment shall be calculated as the prorated share of the net revenues based on the ratio of its nursing wages, salaries and fringe benefits to the total of all nursing wages, salaries and fringe benefits paid by Vermont nursing homes participating in the Medicaid program, as reported on their 1997 Medicaid cost reports.

(2) The wage supplement payments shall be made in monthly installments.

(b) Wage Expenditure Reporting. Within 60 days after the end of each state fiscal year (or part thereof when applicable) during which wage supplement payments are made, each facility shall file on forms prescribed by the Division a report of the wages, salaries, fringe benefits, and bonuses paid to employees during the state fiscal year or part thereof. The filing shall include a calculation of the wage expenditure carryforward which is the difference between subparagraphs (1) and (2):

(1) the facility's expenditures on wages, salaries and fringe benefits, less Christmas bonuses (except for expenditures on wages, salaries, fringe benefits, and bonuses of owners and the administrator) in the baseline period, which shall be the last quarter of calendar year 1998. These expenditures shall be adjusted for accruals and annualized.

(2) the facility's expenditures during the State fiscal year (or part thereof) on wages, salaries and fringe benefits, less Christmas bonuses (except for expenditures on wages, salaries, fringe benefits, and bonuses of owners and the administrator), adjusted for accruals.

(3) Contract Workers. The wages, salaries, fringe benefits, and Christmas bonuses of contractual workers shall be treated as follows:

(i) If a facility incurs no costs for contract staffing in the baseline period in dietary, laundry, housekeeping, or therapies, at such time as the facility converts all staffing in any of these categories exclusively to contractual workers, the facility may remove the salaries of that category from the baseline period or prorated part thereof. No contractual salaries shall be included in the expenditures for the state fiscal year.

(ii) If a facility incurs contract costs for contract staffing in the baseline period in laundry, dietary, or housekeeping, the facility may include the wages, salaries, fringe benefits, less Christmas bonuses of such workers in both the baseline and subsequent state fiscal years as though they were employees of the facility, provided that the amount of the wages, salaries, fringe benefits, and Christmas bonuses of such contract workers can be fully documented for both periods. No amount may be included for any other contract costs, including but not limited to the costs of contractors' employees not actually working at the facility, overhead and profit.

(4) Wage expenditure reports shall be subject to the provisions of these rules relating to cost reports, except where such provisions are incompatible with the specific requirements of this subsection.

(c) Final Calculation of Total Wage Supplement. At such time as all cost categories are rebased on a base year no earlier than 2000, wage supplement payments shall cease. The total amount of each facility's wage supplement shall be the lesser of the cumulative total of the facility's annual wage expenditure carry forward (but not less than zero) or the cumulative total of its wage supplement payments. In making this comparison wage supplement payments and the wage expenditure carry-forward for part of a fiscal year shall be calculated proportionately.

(d) Overpayment. To the extent that a facility's cumulative total of the facility's annual wage expenditure carry forward is lower than a facility's cumulative total of its wage supplement payments, the difference shall be deemed a Medicaid overpayment and shall be recouped pursuant to subsection §5.2(b)(7) to a maximum of the cumulative total of its wage supplement payments.

17.5 Retroactive Payments to State Owned and Operated Nursing Facilities

(a) Notwithstanding any other provision of these rules, for the period from May 1, 1999 though June 30, 2000, or such other later date as may be provided by statute, payment rates for state owned and operated nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services.

(b) No less than 90 days before the beginning of the state fiscal year, a state owned and operated nursing facility shall file with the Division in a form acceptable to the Director, a proposed budget for that fiscal year. The Division shall review this filing for reasonableness and shall determine an approved budget which shall be the basis for the facility's interim rates for that fiscal year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility allowable costs. The Division may limit allowable costs to those in the approved budget.

(d) At no time shall the final rates paid to State owned and operated nursing facilities exceed in aggregate the upper limits established in 42 C.F.R. §447.272(b).

17.6 Increased Indirect Category Limits for Special Hospital-Based Nursing Homes and Reduction in Inflation Factors for All Nursing Homes

(a) Pursuant to the requirements of Act 62 of the 1999 legislative session and notwithstanding the requirements of subsection 7.4, the per diem limit on the base year indirect

per diem rate for special hospital-based nursing facilities shall be 137 percent of the median calculated pursuant to subsection 7.4(c).

(b) The Division shall annually estimate the additional cost of the increase payments to the special hospital-based nursing facilities. These additional costs shall be deducted from the per diem rates of all nursing facilities, but the deduction shall not exceed the estimated total amount of the annual inflation factors established pursuant to subsection 5.8.

(c) For the purposes of this subsection *special hospital-based nursing homes* shall be defined as those homes that meet the following criteria on June 2, 1999:

(1) are physically integrated as part of a hospital building with at least one common wall and a direct internal access between the hospital and the nursing home;

(2) are part of a single corporation that governs both the hospital and the nursing home; and

(3) file one Medicare cost report for both the hospital and the nursing home.

(d) This subsection shall remain in effect from July 1, 1999, though June 30, 2001.